

**MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH**

Do not use this space.

1. PLACE OF DEATH

County _____
Township _____
City St. Louis, Mo. (No. _____)

Registration District No. 791
Primary Registration District No. 1003

File No. 6835
Registered No. 1672
St. _____ Ward _____

2. FULL NAME

Mary Lewkowitz

(a) Residence, No. 5762 Perry Ave. L3 Ward.

Length of residence in city or town where death occurred 6 yrs. 7 mos. 0 ds. How long in U. S., if of foreign birth? yrs. mos. ds.

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Widowed

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (OR) WIFE OF Genie Lewkowitz

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Dec. 25, 1892

7. AGE	YEARS	MONTHS	DAYS	IF LESS than 1 day, _____ hrs. or _____ min.
	<u>57</u>	<u>1</u>	<u>22</u>	

8. OCCUPATION OF DECEASED

(a) Trade, profession, or particular kind of work Housework
(b) General nature of industry, business, or establishment in which employed (or employer) _____
(c) Name of employer _____

9. BIRTHPLACE (CITY OR TOWN) (STATE OR COUNTRY)

Columbus Georgia

10. NAME OF FATHER

Unknown

11. BIRTHPLACE OF FATHER (CITY OR TOWN) (STATE OR COUNTRY)

Poland

12. MAIDEN NAME OF MOTHER

Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) (STATE OR COUNTRY)

Poland

14. INFORMANT (Address)

Joseph Stobbe 5700 General

15. FILED

FEB 17 1930

Max C. Standley
REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 2/17/30 19

17. I HEREBY CERTIFY, That I attended deceased from 2/5/30, 1930, to 2/17/30, 1930, that I last saw him alive on 2/16/30, 1930, and that death occurred, on the date stated above, at 5:30 a.m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:

acute Myocardial Infarction
84

(duration) yrs. mos. 15 da.

CONTRIBUTORY (SECONDARY)

(duration) yrs. mos. ds.

18. WHERE WAS DISEASE CONTRACTED

IF NOT AT PLACE OF DEATH _____

DID AN OPERATION PRECEDE DEATH? No DATE OF _____

WAS THERE AN AUTOPSY? No

WHAT TEST CONFIRMED DIAGNOSIS? Episodic
(Signed) Joseph Stobbe, M. D.

2/17/30, 19 (Address) 5700 General

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) Whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL

DATE OF BURIAL

Lehesed Shel Emeth Cem. 2-17 1930

20. UNDERTAKER

ADDRESS

H. Rindskopf 5216 Delmar

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

2350

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